PROPOSED RULE MAKING

CR-102 (June 2012)
(Implements RCW 34.05.320)
Do **NOT** use for expedited rule making

Agency: Health Care Authority, Washington Apple Health

☒ **Preproposal Statement of Inquiry was filed as WSR** 14-07-020**; or**
☐ **Expedited Rule Making--Proposed notice was filed as WSR; or**
☐ **Proposal is exempt under RCW 34.05.310(4) or 34.05.330(1).**

☒ **Original Notice**
☐ **Supplemental Notice to WSR** _____
☐ **Continuance of WSR** _____

Title of rule and other identifying information:
WAC 182-502-0006 Enrollment for nonbilling providers
WAC 182-502-0010 When the Medicaid agency enrolls
WAC 182-502-0012 When the Medicaid agency does not enroll
WAC 182-502-0016 Continuing requirements

Hearing location(s):
Health Care Authority
Cherry Street Plaza Building; Pear Conf Rm; CSP 107
626 - 8th Avenue, Olympia WA 98504

Metered public parking is available street side around building. A map is available at:
http://www.hca.wa.gov/documents/directions_to_csp.pdf
or directions can be obtained by calling: 360-725-1000

Date: April 21, 2015 Time: 10:00 a.m.

Date of intended adoption: Not sooner than April 22, 2015 (Note: This is **NOT** the **effective** date)

Submit written comments to:
Name: HCA Rules Coordinator
Address: PO Box 45504, Olympia WA, 98504-5504
Delivery: 626 – 8th Avenue, Olympia WA 98504
e-mail arc@hca.wa.gov
fax (360)586-9727

by 5:00 p.m. on April 21, 2015

Assistance for persons with disabilities: Contact Kelly Richters by April 13, 2015

TTY (800) 848-5429 or (360) 725-1307 or e-mail: kelly.richters@hca.wa.gov

Purpose of the proposal and its anticipated effects, including any changes in existing rules:
The agency is proposing amendments to section 182-502-0012 that clarify the scope of the site visit. Additional amendments to sections 182-502-0006, 182-502-0010, and 182-502-0016 clarify provider liability coverage by adding exemptions for providers covered under the Federal Tort Claims Act (FTCA).

Reasons supporting proposal:
The agency aligned site visit requirements with federal regulations under 42 CFR 455.432.
The FTCA protects certain individuals acting within the scope of their official duties from liability. The agency added the reference to the FTCA to reflect these protections.

Statutory authority for adoption: RCW 41.05.021, 41.05.160

Statute being implemented: 42 CFR 455.432

Is rule necessary because of a:

Federal Law?	☒ Yes	☐ No
Federal Court Decision?	☐ Yes	☒ No
State Court Decision?	☐ Yes	☒ No

If yes, CITATION:
42 CFR 455.432

DATE
March 17, 2016

NAME (type or print)
Jason R. P. Crabbe

SIGNATURE

TITLE
HCA Rules Coordinator

CODE REVISER USE ONLY

OFFICE OF THE CODE REVISER
STATE OF WASHINGTON
FILED

DATE: March 17, 2015
TIME: 1:51 PM

WSR 15-07-085

(COMPLETE REVERSE SIDE)

Agency comments or recommendations, if any, as to statutory language, implementation, enforcement, and fiscal matters:
N/A

Name of proponent: Health Care Authority

☐ Private
☐ Public
☒ Governmental

Name of agency personnel responsible for:

	Name	Office Location	Phone
Drafting.....	Chantelle Diaz	PO Box 42716, Olympia, WA 98504-2716	(360) 725-1842
Implementation....	Maureen Guzman	PO Box 45502, Olympia, WA 98504-5502	(360) 725-1622
Enforcement.....Maureen Guzman		PO Box 425502, Olympia, WA 98504-5502	(360) 725-1622

Has a small business economic impact statement been prepared under chapter 19.85 RCW or has a school district fiscal impact statement been prepared under section 1, chapter 210, Laws of 2012?

☐ Yes. Attach copy of small business economic impact statement or school district fiscal impact statement.

A copy of the statement may be obtained by contacting:
Name:
Address:

phone ( ) _____
fax ( )_____
e-mail _____

☒ No. Explain why no statement was prepared.

The Joint Administrative Review Committee has not requested the filing of a small business economic impact statement, and these rules do not impose a disproportionate cost impact on small businesses

Is a cost-benefit analysis required under RCW 34.05.328?

☐ Yes A preliminary cost-benefit analysis may be obtained by contacting:
Name:
Address:

phone ( ) _____
fax ( )_____
e-mail _____

☒ No: Please explain:

RCW 34.05.328 does not apply to Health Care Authority rules unless requested by the Joint Administrative Rules Review Committee or applied voluntarily.

AMENDATORY SECTION (Amending WSR 13-19-037, filed 9/11/13, effective 10/12/13)

WAC 182-502-0006 Enrollment for nonbilling individual providers. (1) The agency pays for health care services, drugs, supplies or equipment prescribed, ordered, or referred by a health care professional only when the health care professional has one of the following approved agreements with the agency and all other conditions of payment have been met (see WAC 182-501-0050):

(a) Core provider agreement, in accordance with WAC 182-502-0005; or

(b) Nonbilling provider agreement, in accordance with subsection (4) of this section.

(2) Only a licensed health care professional whose scope of practice under their licensure includes ordering, prescribing, or referring may enroll as a nonbilling provider.

(3) Nothing in this chapter obligates the agency to enroll any health care professional who requests enrollment as a nonbilling provider.

(4) **Enrollment.**

(a) To enroll as a nonbilling provider with the medicaid agency, a health care professional must, on the date of application:

(i) Not already be enrolled with the medicaid agency as a billing or servicing provider;

(ii) Be currently licensed, certified, accredited, or registered according to Washington state laws and rules;

(iii) Be enrolled with medicare, when required in specific program rules;

(iv) Have current professional liability coverage, individually or as a member of a group, to the extent the health care professional is not covered by the Federal Tort Claims Act, including related rules and regulations;

(v) Have a current federal drug enforcement agency (DEA) certificate, if applicable to the profession's scope of practice;

(vi) Pass the agency's screening process, including license verifications, data base checks, site visits, and criminal background checks, including fingerprint-based criminal background checks as required by 42 C.F.R. 455.434 if considered high-risk under 42 C.F.R. 455.450. The agency uses the same screening level risk categories that apply under medicare. For those provider types that are not recognized under medicare, the agency assesses the risk of fraud, waste, and abuse using similar criteria to those used in medicare;

(vii) Meet the conditions in this chapter and other chapters regulating the specific type of health care practitioner; and

(viii) Sign, without modification, a Medicaid Enrollment Application and Agreement for Nonbilling Individual Providers form (HCA 13-002). The medicaid agency and each provider signing a Medicaid Enrollment Application and Agreement for Nonbilling Individual Providers form (HCA 13-002) will hold each other harmless from a legal action based on the negligent actions or omissions of either party under the terms of this agreement.

(b) The medicaid agency does not enroll a nonbilling provider for reasons which include, but are not limited to, the following:

(i) The agency determines that:

(A) There is a quality of care issue with significant risk factors that may endanger client health and/or safety (see WAC 182-502-0030 (1)(a)); or

(B) There are risk factors that affect the credibility, honesty, or veracity of the health care practitioner (see WAC 182-502-0030 (1)(b)).

(ii) The health care professional:

(A) Is excluded from participation in medicare, medicaid or any other federally funded health care program;

(B) Has a current formal or informal pending disciplinary action, statement of charges, or the equivalent from any state or federal professional disciplinary body at the time of initial application;

(C) Has a suspended, terminated, revoked, or surrendered professional license as defined under chapter 18.130 RCW;

(D) Has a restricted, suspended, terminated, revoked, or surrendered professional license in any state;

(E) Is noncompliant with the department of health's or other state health care agency's stipulation of informal disposition, agreed order, final order, or similar licensure restriction;

(F) Is suspended or terminated by any agency within the state of Washington that arranges for the provision of health care;

(G) Fails a background check, including a fingerprint-based criminal background check, performed by the agency. See WAC 182-502-0014, except that subsection (2) of this section does not apply to nonbilling providers;

(H) Does not have sufficient liability insurance according to (a) ((~~(i)~~)) (iv) of this subsection for the scope of practice, to the extent the health care professional is not covered by the Federal Tort Claims Act, including related rules and regulations; or

(I) Fails to meet the requirements of a site visit, as required by 42 C.F.R. 455.432.

(5) **Effective date of enrollment of nonbilling provider.** Enrollment of a nonbilling provider applicant is effective on the date the agency approves the nonbilling provider application.

(a) A nonbilling provider applicant may ask for an effective date earlier than the agency's approval of the nonbilling provider application by submitting a written request to the agency's chief medical officer. The request must specify the requested effective date and include an explanation justifying the earlier effective date. The chief medical officer will not authorize an effective date that is:

(i) Earlier than the effective date of any required license or certification; or

(ii) More than three hundred sixty-five days prior to the agency's approval of the nonbilling provider application.

(b) The chief medical officer or designee may approve exceptions as follows:

(i) Emergency services;

(ii) Agency-approved out-of-state services;

(iii) Medicaid provider entities that are subject to survey and certification by CMS or the state survey agency;

(iv) Retroactive client eligibility; or

(v) Other critical agency need as determined by the agency's chief medical officer or designee.

(6) **Continuing requirements.** To continue eligibility, a nonbilling provider must:

(a) Only order, refer, or prescribe for clients consistent with the scope of their department of health (DOH) licensure and agency program rules;

(b) Provide all services without discriminating on the grounds of race, creed, color, age, sex, sexual orientation, religion, national origin, marital status, the presence of any sensory, mental or physical handicap, or the use of a trained dog guide or service animal by a person with a disability;

(c) Document that the client was informed that the provider:

(i) May bill the client for any billable item or service. The rules in WAC 182-502-0160 do not apply; and

(ii) Is enrolled with the agency for the sole purpose of ordering, prescribing, or referring items or services for clients.

(d) Inform the agency of any changes to the provider's Medicaid Enrollment Application and Agreement for Nonbilling Individual Providers form (HCA 13-002) including, but not limited to, changes in:

(i) Address or telephone number;

(ii) Business name.

(e) Retain a current professional state license, registration, certification and applicable business license for the service being provided, and update the agency of all changes;

(f) Inform the agency in writing within seven business days of receiving any informal or formal disciplinary order, decision, disciplinary action or other action(s) including, but not limited to, restrictions, limitations, conditions and suspensions resulting from the practitioner's acts, omissions, or conduct against the provider's license, registration, or certification in any state;

(g) Maintain professional liability coverage requirements, to the extent the nonbilling provider is not covered by the Federal Tort Claims Act, including related rules and regulations;

(h) Not surrender, voluntarily or involuntarily, his or her professional state license, registration, or certification in any state while under investigation by that state or due to findings by that state resulting from the practitioner's acts, omissions, or conduct;

(i) Furnish documentation or other assurances as determined by the agency in cases where a provider has an alcohol or chemical dependency problem, to adequately safeguard the health and safety of medical assistance clients that the provider:

(i) Is complying with all conditions, limitations, or restrictions to the provider's practice both public and private; and

(ii) Is receiving treatment adequate to ensure that the dependency problem will not affect the quality of the provider's practice.

(j) Submit to a revalidation process at least every five years. This process includes, but is not limited to:

(i) Updating provider information;

(ii) Submitting forms as required by the agency including, but not limited to, a new Medicaid Enrollment Application and Agreement for Nonbilling Individual Providers form (HCA 13-002); and

(iii) Passing the agency's screening process as specified in subsection (4)(a)(vi) of this section.

(k) Follow the laws and rules that govern the agency's programs. A nonbilling provider may contact the agency with questions regarding the agency's programs. However, the agency's response is based solely on the information provided to the agency's representative at the time of inquiry, and in no way exempts a nonbilling provider from this requirement.

(7) **Audit or investigation.**

(a) Audits or investigations may be conducted to determine compliance with the rule and regulations of the program.

(b) If an audit or investigation is initiated, the provider must retain all original records and supportive materials until the audit is completed and all issues are resolved even if the period of retention extends beyond the required six year period.

(8) **Inspection; maintenance of records.** For six years from the date of services, or longer if required specifically by law, the nonbilling provider must:

(a) Keep complete and accurate medical records that fully justify and disclose the extent of the services or items ordered, referred or prescribed.

(b) Make available upon request appropriate documentation, including client records, supporting material for review by the professional staff within the agency or the U.S. Department of Health and Human Services. The nonbilling provider understands that failure to submit or failure to retain adequate documentation may result in the termination of the nonbilling provider's enrollment.

(9) **Terminations.**

(a) The agency may immediately terminate a nonbilling provider's agreement, and refer the nonbilling provider to the appropriate state health professions quality assurance commission for:

(i) Any of the reasons in WAC 182-502-0030 termination for cause (except that subsection (1)(a)(ix) and (b)(i) do not apply); and

(ii) Failure to comply with the requirements of subsections (4), (6), and (8) of this section.

(b) Either the agency or the provider may terminate this agreement for convenience at any time with thirty calendar days' written notification to the other.

(c) If this agreement is terminated for any reason, the agency will pay for services ordered, referred, or prescribed by the provider only through the date of termination.

(10) **Termination disputes.**

(a) To dispute terminations of a nonbilling provider agreement under subsection (9)(a) of this section, the dispute process in WAC 182-502-0050 applies.

(b) Nonbilling providers cannot dispute terminations under subsection (9)(b) of this section.

AMENDATORY SECTION (Amending WSR 13-03-068, filed 1/14/13, effective 2/14/13)

WAC 182-502-0010 When the medicaid agency enrolls. (1) Nothing in this chapter obligates the medicaid agency to enroll any eligible health care professional, health care entity, supplier or contractor of service who requests enrollment.

(2) To enroll as a provider with the agency, a health care professional, health care entity, supplier or contractor of service must, on the date of application:

(a) Be currently licensed, certified, accredited, or registered according to Washington state laws and rules, or, if exempt under federal law, according to the laws and rules of any other state. Persons or entities outside of Washington state, see WAC 182-502-0120;

(b) Be enrolled with medicare, when required in specific program rules;

(c) Have current professional liability coverage, individually or as a member of a group, to the extent the health care professional, health care entity, supplier or contractor is not covered by the Federal Tort Claims Act, including related rules and regulations;

(d) Have a current federal drug enforcement agency (DEA) certificate, if applicable to the profession's scope of practice;

(e) Meet the conditions in this chapter and other chapters regulating the specific type of health care practitioner;

(f) Sign, without modification, a core provider agreement (CPA) (HCA 09-015), disclosure of ownership form, and debarment form (HCA 09-016) or a contract with the agency;

(g) Agree to accept the payment from the agency as payment in full (in accordance with 42 C.F.R. § 447.15 acceptance of state payment as payment in full and WAC 182-502-0160 billing a client);

(h) Fully disclose ownership, employees who manage, and other control interests (e.g., member of a board of directors or office), as requested by the agency. Indian health services clinics are exempt from this requirement. If payment for services is to be made to a group practice, partnership, or corporation, the group, partnership, or corporation must enroll and provide its national provider identifier (NPI) (if eligible for an NPI) to be used for submitting claims as the billing provider;

(i) Have screened employees and contractors with whom they do business prior to hiring or contracting to assure that employees and contractors are not excluded from receiving federal funds as required by 42 U.S.C. 1320a-7 and 42 U.S.C. 1320c-5;

(j) Pass the agency's screening process, including license verifications, data base checks, site visits, and criminal background checks, including fingerprint-based criminal background checks as required by 42 C.F.R. 455.434 if considered high-risk under 42 C.F.R. 455.450. The agency uses the same screening level risk categories that apply under medicare. For those provider types that are not recognized under medicare, the agency assesses the risk of fraud, waste, and abuse using similar criteria to those used in medicare; and

(k) Agree to pay an application fee, if required by CMS under 42 C.F.R. 455.460.

AMENDATORY SECTION (Amending WSR 13-17-047, filed 8/13/13, effective 10/1/13)

WAC 182-502-0012 When the medicaid agency does not enroll. (1) The medicaid agency does not enroll a health care professional, health care entity, supplier, or contractor of service for reasons which include, but are not limited to, the following:

(a) The agency determines that:

(i) There is a quality of care issue with significant risk factors that may endanger client health ((~~and/or~~)), or safety, or both (see WAC 182-502-0030 (1)(a)); or

(ii) There are risk factors that affect the credibility, honesty, or veracity of the health care practitioner (see WAC 182-502-0030 (1)(b)).

(b) The health care professional, health care entity, supplier or contractor of service:

(i) Is excluded from participation in medicare, medicaid or any other federally funded health care program;

(ii) Has a current formal or informal pending disciplinary action, statement of charges, or the equivalent from any state or federal professional disciplinary body at the time of initial application;

(iii) Has a suspended, terminated, revoked, or surrendered professional license as defined under chapter 18.130 RCW;

(iv) Has a restricted, suspended, terminated, revoked, or surrendered professional license in any state;

(v) Is noncompliant with the department of ((~~health's~~)) health or other state health care agency's stipulation of informal disposition, agreed order, final order, or similar licensure restriction;

(vi) Is suspended or terminated by any agency within the state of Washington that arranges for the provision of health care;

(vii) Fails a background check, including a fingerprint-based criminal background check, performed by the agency. See WAC 182-502-0014 and 182-502-0016; or

(viii) Does not have sufficient liability insurance according to WAC 182-502-0016 for the scope of practice((~~; or~~

~~(ix) Fails to meet the requirements of a site visit, as required by 42 C.F.R. 455.432~~)), to the extent the health care professional, health care entity, supplier or contractor of service is not covered by the Federal Tort Claims Act, including related rules and regulations.

(c) A site visit under 42 C.F.R. 455.432 reveals that the provider has failed to comply with a state or federal requirement.

(2) The agency may not pay for any health care service, drug, supply or equipment prescribed or ordered by a health care professional, health care entity, supplier or contractor of service whose application for a core provider agreement (CPA) has been denied or terminated.

(3) The agency may not pay for any health care service, drug, supply, or equipment prescribed or ordered by a health care professional, health care entity, supplier or contractor of service who does not have a current CPA with the agency when the agency determines there is a potential danger to a client's health and/or safety.

(4) Nothing in this chapter precludes the agency from entering into other forms of written agreements with a health care professional, health care entity, supplier or contractor of service.

(5) If the agency denies an enrollment application, the applicant does not have any dispute rights within the agency.

(6) Under 42 C.F.R. 455.470, the agency:

(a) Will impose a temporary moratorium on enrollment when directed by CMS; or

(b) May initiate and impose a temporary moratorium on enrollment when approved by CMS.

AMENDATORY SECTION (Amending WSR 13-03-068, filed 1/14/13, effective 2/14/13)

WAC 182-502-0016 Continuing requirements. (1) To continue to provide services for eligible clients and be paid for those services, a provider must:

(a) Provide all services without discriminating on the grounds of race, creed, color, age, sex, sexual orientation, religion, national origin, marital status, the presence of any sensory, mental or physical handicap, or the use of a trained dog guide or service animal by a person with a disability;

(b) Provide all services according to federal and state laws and rules, medicaid agency billing instructions, numbered memoranda issued by the agency, and other written directives from the agency;

(c) Inform the agency of any changes to the provider's application or contract, including but not limited to, changes in:

(i) Ownership (see WAC 182-502-0018);

(ii) Address or telephone number;

(iii) Professional practicing under the billing provider number; or

(iv) Business name.

(d) Retain a current professional state license, registration, certification and applicable business license for the service being provided, and update the agency of all changes;

(e) Inform the agency in writing within seven calendar days of changes applicable to the provider's clinical privileges;

(f) Inform the agency in writing within seven business days of receiving any informal or formal disciplinary order, decision, disciplinary action or other action(s), including, but not limited to, restrictions, limitations, conditions and suspensions resulting from the practitioner's acts, omissions, or conduct against the provider's license, registration, or certification in any state;

(g) Screen employees and contractors with whom they do business prior to hiring or contracting, and on a monthly ongoing basis thereafter, to assure that employees and contractors are not excluded from receiving federal funds as required by 42 U.S.C. 1320a-7 and 42 U.S.C. 1320c-5;

(h) Report immediately to the agency any information discovered regarding an employee's or contractor's exclusion from receiving federal funds in accordance with 42 U.S.C. 1320a-7 and 42 U.S.C. 1320c-5. See WAC 182-502-0010 (2)(j);

(i) Pass any portion of the agency's screening process as specified in WAC 182-502-0010 (2)(j) when the agency requires such information to reassess a provider;

(j) Maintain professional and general liability coverage ((~~requirements, if not covered~~)) to the extent the provider is not covered:

(i) Under agency, center, or facility((~~, in the amounts identified by the medicaid agency~~)) professional and general liability coverage; or

(ii) By the Federal Tort Claims Act, including related rules and regulations;

(k) Not surrender, voluntarily or involuntarily, his or her professional state license, registration, or certification in any state while under investigation by that state or due to findings by that state resulting from the practitioner's acts, omissions, or conduct;

(l) Furnish documentation or other assurances as determined by the agency in cases where a provider has an alcohol or chemical dependency problem, to adequately safeguard the health and safety of medical assistance clients that the provider:

(i) Is complying with all conditions, limitations, or restrictions to the provider's practice both public and private; and

(ii) Is receiving treatment adequate to ensure that the dependency problem will not affect the quality of the provider's practice; and

(m) Submit to a revalidation process at least every five years. This process includes, but is not limited to:

(i) Updating provider information including, but not limited to, disclosures;

(ii) Submitting forms as required by the agency including, but not limited to, a new core provider agreement; and

(iii) Passing the agency's screening process as specified in WAC 182-502-0010 (2)(j).

(2) A provider may contact the agency with questions regarding its programs. However, the agency's response is based solely on the information provided to the agency's representative at the time of inquiry, and in no way exempts a provider from following the laws and rules that govern the agency's programs.

(3) The agency may refer the provider to the appropriate state health professions quality assurance commission.